VERMONT

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ LONG ACTING NARCOTICS~

Prior Authorization Request Form

Vermont Medicaid has established coverage limits and criteria for prior authorization of long acting narcotics. These limits and criteria are based on concerns about safety and the potential for abuse and diversion. In order for beneficiaries to receive coverage for this drug, it will be necessary for the prescriber to telephone or complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____ Sex:_____

Contact Person at Office:_____

Drug Requested:

Please indicate: Brand Name □ or Generic Equivalent □

Dose /Frequency and Length of Therapy:

Diagnosis or Indication for Use::

Has the member previously tried any of the following preferred medications?

Check all that apply:	***Response, check all that apply:***
□ Duragesic Patches	□ side-effect □ non-response □ allergy
□ Methadone	□ side-effect □ non-response □ allergy
□ Morphine Sulfate SR 12 Hr	□ side-effect □ non-response □ allergy

Is this an initial request or a subsequent request? □ Initial □ Subsequent

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____